

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155677		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2011	
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 725 BELL TRACE CIR BLOOMINGTON, IN 47408			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 25, 26 and 27, 2011</p> <p>Facility number: 002574 Provider number: 155677 AIM number: N/A</p> <p>Survey team: Marla Potts, RN TC Melinda Lewis, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF: 69 Total: 69</p> <p>Census payor type: Medicare: 28 Other: 41 Total: 69</p> <p>Sample: 15</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 8/2/11 by Jennie Bartelt, RN.</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>						

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	<p>Based on interview and record review, the facility failed to ensure staff reported an allegation of verbal abuse timely, for 1 of 15 residents reviewed for abuse in the sample of 15. (Resident #66)</p> <p>Findings include:</p> <p>Resident #66's record was reviewed on 7/25/11 at 9:30 A.M. The record included a facility incident reporting form, dated 7/14/11, which indicated the form had been sent to the physician for notification of an allegation of verbal abuse.</p> <p>The Health Facility Administrator provided the investigation of the abuse on 7/25/11 at 10:00 A.M. The report indicated CNA #1 had observed LPN #1 was yelling and told Resident #66, "Shut up and be quiet now." The report indicated CNA #1 heard this as he exited another resident's room. The report indicated CNA #1 indicated he heard LPN #1 yelling at the resident on 7/9/11, but did not report the occurrence to anyone until 7/13/11. During the interview, conducted by the Director of Nursing (DoN) with CNA #1, and recorded as part of the investigation, CNA #1 indicated "he was surprised by what he witnessed and did not say anything." He felt like LPN #1 did not like him and that she didn't treat the residents to his liking. He</p>		F0225	<p>This plan offi correctton is tto serve as Bell Trace Health and Living Center' s credible allegatton offi compliance Submission offi tthis plan offi correctton does nott consttttute an admission by Bell Trace Health and Living Centter or ittts managementt company tthatt tthe allegattons contained in tthe survey reportt are a ttrue and accuratte porttrayal offi tthe provision offi nursing care and other services in tthis ffiacilityt Nor does tthis submission consttttute an agreementt or admission offi tthe survey allegattons.</p> <p>F 225 483.13(c)(1)(ii)-(iii), (c)(2) – (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>I. The CNA (#1) involved has received one-on-one ttraining on tmely nottffication offi allegattons offi abuse and has demonstrttated comprehension offi tthe infformatton by a posttttestt</p> <p>II. All sttaffi will be provided with ttraining on abuse identtffication and tmely reporttng upon hire and quartertly New sttaffi will also receive secondary reffresher ttraining during tthe second week offi employmentt provided by a menttor</p> <p>III. Systemic change is a ffiactt offi face reinfforced educatton provided by tthe DON and/or designee regarding tmely nottffication offi allegattons offi abuse tto all new employees in</p>		08/26/2011	

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F0226 SS=D	<p>also stated he didn't like to work on that unit.</p> <p>During interview on 7/25/11 at 10:30 A.M., the DoN indicated CNA #1 had first told the Human Resources person, who immediately reported it to Social Services and the Health Facility Administrator on 7/13/11.</p> <p>3.1-28(c)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure CNA #1 followed policy and procedure for immediately reporting an allegation of verbal abuse, for 1 of 15 residents reviewed for abuse in</p>			F0226	<p>additton tto tthe currentt educatton Educatton will contnue tto be provided upon hire and att leastt quarterly tthereaffier IV. The Administtrator an/br designee will review 100% offi all allegattons offi abuseupon occurrence, ffio12 monthts This review will include tthe ttmeliness offi reporttngAny identtffied concerns will be addressed immediattely In additton, interviews offi sttaffi regarding awareness offi ttmeliness offi reporttng will be conducted by tthe Administtrator or designee weekly ffio30 days, tthen every otther week ffio30 days, tthen monthly tthereaffier ffior duratton offi 12 monthts offi monittoring</p> <p>The resultts offi tthese auditts will be discussed att tthe monthtly ffiacility Qualitty Assurance Committee meetng and ffirequency and duratton offi reviews will be adjustted as needed.</p> <p>Complettion Datte Augustt26, 2011</p> <p>This plan offi correcttion is tto serve as Bell Trace Healtht and Living Center' s credible allegatton offi compliance Submission offi tthis plan offi correcttion does nott consttttute an admission by Bell Trace Healtht and Living Center or ittts managementt</p>		08/26/2011

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	<p>the sample of 15. (Resident #66)</p> <p>Findings include:</p> <p>Resident #66's record was reviewed on 7/25/11 at 9:30 A.M. The record included a facility incident reporting form, dated 7/14/11, indicating the form had been sent to the physician for notification of an allegation of verbal abuse.</p> <p>The Health Facility Administrator (HFA), provided the investigation of the abuse on 7/25/11 at 10:00 A.M. The report indicated CNA #1 had observed LPN #1 was yelling and told Resident #66, "Shut up and be quiet now." The report indicated CNA #1 heard this as he exited another resident's room. The report indicated CNA #1 indicated he heard LPN #1 yelling at the resident on 7/9/11, but did not report the occurrence to anyone until 7/13/11. During the interview, conducted by the Director of Nursing (DoN) with CNA #1, and recorded as part of the investigation, CNA #1 indicated "he was surprised by what he witnessed and did not say anything". He indicated he felt like LPN #1 did not like him and that she didn't treat the residents to his liking. He also stated he didn't like to work on that unit.</p> <p>During interview on 7/25/11 at 10:30</p>				<p>company thtatt tthe allegattions contained in tthe survey reportt are a ttrue and accuratte porttrayal offi tthe provision offi nursing care and other services in ttthis ffiacilitt. Nor does ttthis submission constttttute an agreementt or admission offi tthe survey allegattions.</p> <p>F 226 483.13(c) DEVELOPMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>I. The CNA (#1) involved has received one-on-one training on timely notification of allegations of abuse and has demonstrated comprehension of the information by a post-test.</p> <p>II. All staff will be provided with training on abuse identification and timely reporting upon hire and quarterly. New staff will also receive secondary refresher training during the second week of employment provided by a mentor.</p> <p>III. Systemic change is a face-to-face reinforced education provided by the DON and/or designee regarding timely notification of allegations of abuse to all new employees in addition to the current education. Education will continue to be provided upon hire and at least quarterly</p>		

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	<p>A.M., the DoN indicated CNA #1 had first told the Human Resources person, who immediately reported it to Social Services and the Health Facility Administrator on 7/13/11.</p> <p>The facility policy and procedure for Abuse Prevention, dated 4/2011, provided by the HFA on 7/25/11 at 9:30 A.M. included: "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitor etc, to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to the Administrator or Designee if Administrator is unavailable... The Administrator and Director of Nursing must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident...."</p> <p>3.1-28(a)</p>				<p>thereafter.</p> <p>IV.</p> <p>The Administrator and/or designee will review 100% of all allegations of abuse, upon occurrence, for 12 months. This review will include the timeliness of reporting. Any identified concerns will be addressed immediately. In addition, interviews of staff regarding awareness of timeliness of reporting will be conducted by the Administrator or designee weekly for 30 days, then every other week for 30 days, then monthly thereafter for duration of 12 months of monitoring.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Completion Date: August 26, 2011</p>		

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F0314 SS=G	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident did not develop a pressure sore while residing in the facility, in that Resident #46 developed an unstageable pressure sore to her heel from a walking brace, for 1 of 3 residents reviewed with pressure sores in a sample of 15.</p> <p>Findings include:</p> <p>On the initial tour, on 7/25/11 at 8:00 A.M., the Unit Manager indicated Resident #46 was not interviewable.</p> <p>On 7/25/11 at 8:30 A.M., Resident # 46 was observed to be sitting in a chair in her room. Resident # 46 was observed to have a multipodous boot on her right foot.</p> <p>On 7/26/11 at 10:40 A.M., Resident # 46 was observed to be in bed on left side. Resident # 46's right heel was observed to be approximately 4 cm by 2.5 cm brown</p>		F0314	<p>This plan off correctcton is tto serve as Bell Trace Health and Living Centttr's credible allegatton off compliance Submission off tthis plan off correctcton does nott constttttute an admission by Bell Trace Health and Living Centttr or ittts managementt company tthat tthe allegattons contained in tthe survey reportt are a ttrue and accuratte porttrayal off tthe provision off nursing care and otther services in tthis ffacilityNor does tthis submission constttttute an agreementt or admission off tthe survey allegattons.</p> <p>F 314 483.25(C) TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES I. Residentt#46 has had a complete skin assessmentt performed and is receiving appropriate ttreatmentt weekly skin assessmentts and preventttattve care There is evidence on tthe weekly wound assessmentts tthat tthe wound is healing II.</p>		08/26/2011	

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	<p>area.</p> <p>The clinical record for Resident # 46 was reviewed on 7/25/11 at 7:45 A.M. The record indicated Resident # 46 had diagnoses that included, but were not limited to, dementia and right heel fracture. The MDS [minimum data set] assessment, dated 4/21/11, indicated Resident # 46 had severely impaired cognition, and required extensive assistance of two with bed mobility and transfers. Resident # 46 had no pressure areas.</p> <p>A Care plan, dated 4/13/11, indicated, "Resident is at risk for skin breakdown R/T [related to] demenita, poor po [by mouth] intake poor mobility splint/brace on RLE [right lower extremity]." The interventions were "Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences. Encourage physical activitiy, mobility and ROM [range of motion] to maximal potential. Keep clean and dry as possible minimize skin exposure to moisture. Keep linen clean dry and wrinkle free. Monitor skin every shift around splint/brace."</p> <p>A Physician Progress Note, dated 7/6/11, indicated, "...OK to ambulate cont [continue] Cam walker x [times 2 weeks...swelling post [posterior] Rt</p>				<p>All residents at risk for pressure sores have been identified, a plan of care has been written for prevention of skin breakdown and appropriate interventions have been implemented. In addition, a facility wide skin sweep has been conducted and no other pressure areas were found.</p> <p>III.</p> <p>A systemic change includes</p> <ul style="list-style-type: none"> • Skin sheets are now being utilized at least weekly during the resident's shower/bath. Any area of concern will be assessed by the nurse and reported to the Unit Manager. • Weekly skin assessments will be completed in addition to the above by licensed nurses • New admissions and residents with a significant change that increases their risk of skin breakdown will be discussed during the weekly interdisciplinary "At Risk Meeting" to review for appropriate interventions, care planning and implementation of preventative care. • New orders and significant changes will be discussed at the daily (Monday through Friday) clinical meeting to target residents that may require changes in interventions and care planning • is evidenced by the Director of Nursing and/or designee auditing and reviewing all weekly skin 		

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	<p>[right] heel..."</p> <p>In an interview with the Unit Manager, on 7/27/11 at 10:30 A.M., he indicated Resident # 46 had her soft cast removed on 7/6/11, but continued to utilize the Cam walker. He indicated there was no documentation from admission until 7/13/11 concerning Resident # 46's right heel.</p> <p>A Skin Inspection Tool, dated 7/13/11, indicated, "Skin Description, Prevention and Treatment- Turning and repositioning per care plan, pressure device in chair, pillows/cushions used to prevent bony prominences from rubbing. 2.0 cm x [by] x unstageable area noted on R [right] heel edges flaky- center dry with drk [dark] center. Remaining W/D/I [warm/dry/intact]."</p> <p>A Physician order, dated 7/13/11, indicated, "Apply skin prep to Rt [right] heel BID (two times daily)."</p> <p>A Physician Wound Sheet, dated 7/19/11, indicated, "...R [right] heel 1.8 x [by] 1.3 x 0.1 cm...pressure devices related unstageable...100% Fibrin/slough...unstageable device related pressure ulcer heel..."</p> <p>A Physician order, dated 7/19/11,</p>			<p>assessments for completion</p> <p>Residents with new areas of concern will be targeted for weekly visits by a wound professional. Residents with active pressure sores will be reviewed weekly by the Interdisciplinary Team to evaluate progress of the wound appropriateness of the current interventions and the need for changes to the plan of care. In addition, the clinical team will review the plan of care and the plan of treatment related to skin and pressure sores, for all new admissions, residents exhibiting a significant change and other residents as needed during the daily clinical meeting Monday through Friday.</p> <p>Education will be provided to all nursing staff regarding</p> <ul style="list-style-type: none"> Use of the new skin sheets weekly during the resident's shower/bath and assessment of the skin if any concerns are found Weekly skin assessments Appropriate interventions care planning and implementation of preventive measures to avoid/prevent the development of pressure ulcers. <p>about the admission skin assessment program, weekly skin assessments and shower sheets to be completed by the CNAs IV.</p> <p>The DON and/or designee will audit:</p>			

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	<p>indicated, "...2. Cleanse R [right] heel wound with NS [normal saline] pat dry apply skin prep to edges and santyl to OA [open area]. Cover with hydrogel and soaked fluffed gauze and secure . Change daily. 3. PT [physical therapy] to eval [evaluate] for footwear to offload R heel wound."</p> <p>A Skin Inspection Tool, dated 7/21/11, indicated, "...See Wound Dr. progress note- 7-19-11 for wound description and measurements. Remaining skin W/D/I lotion applied to skin with care."</p> <p>A Physician order, dated 7/22/11, indicated, "1. D/C [discontinue] PT order, pt [patient] to wear multipodus boot at all times, staff to do frequent checks for fitting/positioning to maintain proper heel off loading. 2. May D/C Cam walker boot per Dr (name) telephone order."</p> <p>In an interview with the Unit Manager, on 7/27/11 at 10:30 A.M., he indicated he thought the Cam walker boot was what had caused the area to Resident # 46's heel.</p> <p>3.1-40(a)(1)</p>			<p>· For completton off weekly skin sheetts with tthe residentt's shower/batth and ffollow up iff indicattted by tthe licensed nurse weekly ffor12 monthts</p> <p>· For completton off weekly skin assessmттts by licensed nurses and ffollow up iff indicattted weekly ffo2 monthts</p> <p>· New admissions and residentts with signiffcantt change tthatt increase ttheir risk off skin breakdown ffor appropriate interrvттттттs and care planning weekly ffor12 monthts</p> <p>· For implementatttt offi interrvттттттs tthrough rounds weekly ffo12 monthts</p> <p>skin assessments ffo100% offi all new admissions ffo12 monthts to include completton, implementatttt offi appropriate interrvттттттs and a written plan offi care. Weekly auditts will also be perfformed ffor completton offi weekly skin assessmттттs ffor all residentts Addittttional auditts will be perfformed weekly ffor residentts with existtng pressure sores to evaluatte tthe appropriatttneess offi tthe interrvттттттs plan offi care and insure tthatt tthe CNA assignmтттт sheetts are updattdThis auditt will also assess tthe Interdisciplinary Team's weekly involvemтттт in monitttoring planning and evaluattng tthe care offi pressure sores.</p> <p>The resultts offi tthese auditts will be</p>			

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F0323 SS=G	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure a resident with a history of falls and at risk of falls was provided supervision and measures implemented to prevent falls, with the resident falling and receiving a laceration which required sutures, for 1 of 8 residents reviewed for falls, in the sample of 15. (Resident #51)</p> <p>Findings include:</p> <p>During interview on the initial tour on 7/25/11 at 8:00 A.M., the Unit Manager indicated Resident #51 was confused and hard of hearing, and had no recent falls.</p> <p>The clinical record for Resident # 51 was reviewed on 7/26/11 at 1:00 P.M. The record indicated Resident # 51 had diagnoses that included, but were not limited to, Alzheimer's dementia, chronic vertigo, hearing loss and left eye blindness. The MDS [minimum data set]</p>	F0323	<p>discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Completion Date August 26, 2011</p> <p>This plan of correction is to serve as Bell Trace Health and Living Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Bell Trace Health and Living Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>F 323.483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES THE FACILITY RESPECTFULLY REQUESTS IDR FOR THIS CITATION.</p> <p>I. Resident #51's Plan of Care has been reviewed and interventions are in place to prevent further falls.</p> <p>II.</p>	08/26/2011	

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	<p>assessment, dated 7/5/11, indicated Resident # 51 had severely impaired cognition. Resident # 51 required extensive assistance of one with bed mobility, transfers and ambulation. Resident # 51 had fallen one time since admission without injury.</p> <p>A Care plan, dated 2/17/11, indicated a problem of "Resident has risk for falls/injuries R/T [related to] osteoporosis; dementia, vertigo, decreased mobility." The interventions were "Give resident verbal reminders not to ambulate/transfer without assistance. Keep personal items and frequently used within reach. Provide proper, well-maintained footwear."</p> <p>The Resident Progress Notes, dated 3/2/11 at 7:09 A.M., indicated, "At 4:45 A.M. resident sitting on floor at foot of bed, unable to tell how fell, denied pain, two assist up, able to bear weight w/o [without] pain/discomfort, assisted to BR [bathroom], AROM [active range of motion] w/o complaints pain/discomfort, no new marks/bruises noted, neuro checks started as precaution on call md Dr (name) notified at 530 am..."</p> <p>The 2/17/11 fall care plan was updated on 3/2/11 to include the intervention of "Resident's bed placed against wall, mat on floor beside bed."</p>				<p>All residents who have fallen in the past three months or who are at risk for falls have had their Plan of Care reviewed for appropriate fall prevention interventions.</p> <p>III.</p> <p>A systemic change includes a thorough interdisciplinary investigation for all new fall incidences daily (Monday through Friday) at the clinical meeting with a review of all current interventions, updating of the plan of care, and the need for additional interventions. Education will be provided to staff regarding fall prevention, fall investigation, immediate fall interventions and communication of these interventions on the Plan of Care and the CNA assignment sheets.</p> <p>IV.</p> <p>Audits will be conducted by the Director of Nursing and/or designee for all falls for 12 months, daily (Monday through Friday) regarding a review of all current interventions, updating of the plan of care and a new intervention. In addition, the Director of Nursing or designee will be notified of all falls during non-business hours to discuss</p>		

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	<p>The Interdisciplinary Team Meeting Fall Interventions, dated 3/2/11, indicated, "...found on floor at FOB [foot of bed]...New Intervention(s) low bed with mat. Resident bed placed along wall..."</p> <p>The Resident Progress Notes, dated 4/10/11 at 2:19 P.M., indicated, "Resident found on floor bedside bed, PSA [personal safety alarm] was sounding. Head to toe assessment completed no injuries notes. Resident having no c/o [complaints of] pain or signs of distress. Family notified of fall and of new intervention..."</p> <p>The Interdisciplinary Team Meeting Fall Interventions, dated 4/11/11, indicated, "...4-10-11, 11:00 AM, resident's PSA sounded I entered resident's room to find resident on the floor beside her bed...New Intervention(s) Moved bed against wall, placed in low position, PSA to floor mat next to bed..."</p> <p>The 2/17/11 fall care plan was updated on 4/11/11, to include the intervention of "Equip resident with device that monitors rising (PSA in bed, floor beside bed and wheelchair)."</p> <p>The Resident Progress Notes, dated 4/15/11 at 6:50 P.M., indicated, "Resident</p>				<p>current interventions and new interventions to be implemented. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Completion Date: August 26, 2011</p>		

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	<p>was sitting in the wheelchair at bedside. Nurse came into the room to give resident her medication. Resident sneezed Resident pitched forward when she sneezed, and continued to fall forward onto the floor. Resident c/o pain to her forehead. Full skin and head to toe assessment performed. Neurostatus charting started. Resident has a 1 inch laceration to lower lip, and a 3 inch lump to forehead. Cleaned laceration, applied ice to lump on forehead."</p> <p>The Resident Progress Notes, dated 4/29/11 at 4:45 P.M., indicated, "Resident's PSA going off, resident yelling for help. Resident found to be laying on floor. Full head to toe assessment performed. Resident found to have a 1 inch laceration to forehead above L [left] eye, 1/2 inch laceration to side of L eye, and 1/2 inch laceration under L eye. Resident also noted to have a small laceration to back of head. Cleaned wounds, applied pressure to stop bleeding...Resident transported to (hospital name) to receive stitches."</p> <p>The 2/17/11 fall care plan was updated on 4/29/11 to include the interventions of "Keep bed in lowest position with brakes locked, Observe frequently and place in supervised area when out of bed, and Provide toileting assistance every 2 hours</p>						

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	<p>and PRN [as needed] while awake."</p> <p>The Interdisciplinary Team Meeting Fall Interventions, dated 4/29/11, indicated, "...Resident's PSA was alarming, resident was yelling. Resident found laying on the floor. 3 i [one] inch lacerations noted to L [left] cheek and above L eye. Cleaned wounds, applied pressure...New intervention(s) Provide toileting q [every] 2 hours and PRN while awake..."</p> <p>The Resident Progress Notes, dated 5/18/11 at 4:20 P.M., indicated, "This nurse heard resident's PSA sounding and entered resident's bathroom to see her standing between her wheelchair and the toilet. Before this nurse could reach her, resident twisted to sit on floor with her back to the sink, then fell back and hit the back of her head on the trash can. Two staff to place resident back in wheelchair. Res alert, never lost consciousness, denies any pain. No injuries noted. Neuro checks initiated and are within normal limits. Resident helped to toilet with no output..."</p> <p>The Interdisciplinary Team Meeting Fall Interventions, dated 5/23/11, indicated, "...Pt [patient] trying to transfer self to toilet without assistance...New intervention(s) encourage resident to be out of room when in w/c. Bathroom door to remain closed when not in use..."</p>						

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F0356 SS=C	<p>3.1-45(a)(2)</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the daily staffing was posted correctly for 1 of 3 days</p>			F0356	<p>This plan offi correctton is tto serve as Bell Trace Healthh and Living Center' s credible allegatton offi compliance Submission of this plan of</p>		08/26/2011

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	<p>reviewed, in that on Monday morning the staffing for the previous Friday was still posted. This potentially could have affected all 69 of 69 residents and/or their families.</p> <p>Findings include:</p> <p>On 7/25/11 at 7:30 A.M. the facility staffing was observed posted in the hallway at the main entrance of the facility. The posting was dated 7/22/11.</p> <p>During interview with the Health Facility Administrator (HFA) on 7/25/11 at 9:00 A.M., he indicated the Staff Development Coordinator was responsible for posting the staffing through the week but left a form for the week-end Receptionist for Saturday and Sunday. On 7/26/11 at 11:00 A.M., the HFA indicated the Receptionist had just failed to post the forms this past week-end.</p> <p>3.1-13(a)</p>				<p>correction does not constitute an admission by Bell Trace Health and Living Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>POSTED NURSE STAFFING INFORMATION</p> <p>I. Nurse staffing hours are being posted daily seven days per week.</p> <p>II. Nurse staffing hours are posted at the main entrance and on each nursing station at the nurses' desk daily.</p> <p>III. The systemic change includes the Weekend Manager will be responsible for the posting of the daily nurse staffing hours on weekends. The Director of Nursing or designee, will be responsible for posting of the nurse staffing hours Monday through Friday. Education will be provided about the systemic change regarding posting of daily nurse staffing hours to licensed nurses.</p> <p>IV. The Director of Nursing and/or designee will audit daily posting of</p>		

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					<p>nurse staffing hours randomly throughout the week and weekend 3 times a week for 30 days then on random days weekly for 30 days then monthly for a total duration of 2 months</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Completion Date August 26, 2011 F 356 483.30(e)</p>		